



# Change of Address/Name Form

Employer name \_\_\_\_\_

Effective date of change \_\_\_\_\_

## Employee Please print legibly in blue or black ink.

SSN	Name (last, first, initial)	Date of birth	Gender
New home / mailing address		Phone (with area code)	
City	State	Zip	Email address

## Your signature is required Address cannot be updated without your signature.

I hereby apply for coverage under the contract between the respective insurance company and my employer and AWC, and I agree with the terms of the contract. I also apply for the same coverage for my spouse and/or dependent children listed on this application. I certify that my dependents and I meet all the eligibility criteria set forth in the outline or benefits and/or the Contract.

I have provided these answers as part of the application procedure required by the insurance carriers listed on the bottom of this form to enroll in coverage and I certify that all information completed on this form is true, correct, and complete. I understand that the insurance carriers will rely on each answer in making coverage and rating determinations. If the insurance carriers continue the contract with the AWC Trust and my employer after untrue, incorrect, or incomplete information is found to have been provided, and if as a result of correcting false information the Group no longer qualifies for the rate quoted, I understand that the insurance carriers will have the right to adjust the rates to the appropriate level retroactive to the date the misrepresentation occurred, and the Group will be required to pay the rate adjustment within 30 days of the date of notice by the insurance carriers. For the protection of all of our members, knowingly providing us with false, incomplete, or misleading information may result in the insurance carriers taking any action allowed by law or Contract, including termination or rescission of coverage, denial of benefits, and/or pursuit of criminal charges and penalties. In addition, the insurance carriers will have the right to collect any claims payments or other damages.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Note:** For any other changes to your benefits, please complete the AWC Combined Insurance Enrollment Form.

**Employer:** Please send completed form to: AWC Employee Benefit Trust  
1076 Franklin Street SE  
Olympia, WA 98501



**Regence BlueShield**  
1800 Ninth Ave  
Seattle, WA 98101



**Asuris Northwest Health**  
528 E Spokane Falls Blvd,  
Suite 301  
Spokane, WA 99202



**Kaiser Foundation Health Plan of Washington/Kaiser Foundation Health Plan of Washington Options Inc.**  
320 Westlake Ave N, Ste 100  
Seattle, WA 98109-5233



Delta Dental of Washington  
**Delta Dental of Washington**  
9706 Fourth Ave NE  
Seattle, WA 98115



**Vision Service Plan**  
3333 Quality Drive  
Rancho Cordova, CA 95670



**ComPsych**  
NBC Tower  
455 N. Cityfront Plaza Drive  
Chicago, IL 60611-5322



**Standard Insurance Company**  
1100 SW 6th Ave.  
Portland, OR 97204



**Willamette Dental of Washington, Inc.**  
6950 NE Campus Way  
Hillsboro, OR 97124